	FO	R OHF	USE		

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2001 STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2001)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 0018150	п.	CERTIFICATION BY AUTHORIZED FACILITY OFFICER
	Facility Name: McLean County Nursing Home Address: 901 North Main Street Number City County: McLean Telephone Number: (309) 888-5380 Fax # (309) 454-4594	61761 Zip Code	I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.
	Date of Initial License for Current Owners: Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Date of Initial License for Current Owners: 01-0 PROPRIETAR	Officer of Administration of Provi	strator (Type or Print Name) Donald Lee
	Trust Partners IRS Exemption Code Corpora "Sub-S"	ip X County Other	(Signed) March 20, 2002 (Date) (Print Name Robert Rein
		iability Co. Prepare	And Title) Practitioner (Firm Name Robert Rein, CPA Address) P.O. Box 201, Morton, Illinois 61550-0201 (Telephone) (309) 266-8178 Fax # ()
	In the event there are further questions about this report, please contact: Name: Donald Lee Telephone Number:	(309) 888-5380	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

STATE OF ILLINOIS Page 2

Facil	lity Name & ID Numbe	er McLean County N	Nursing Home			# 0018150 Report F	Period Beginning:	01/01/2001 Eı	iding: 12/31/2001
	III. STATISTICA	L DATA				D. How many bed-hold days d	uring this year were paid	d by Public Aid?	
		ertification level(s) of care	e; enter number of be	ds/bed days,		•	include bed-hold days in	•	
	(must agree	with license). Date of chan	ge in licensed beds	• •			v	,	
	(8			E. List all services provided by	vour facility for non-na	atients.	
	1	2		3	4	(E.g., day care, "meals on wh	• •		
	1			T	1		reels , outputient therap	,;)	
	Beds at				Licensed				
	Beginning of	Licensure		Beds at End of	Bed Days During	F. Does the facility maintain a	daily midnight consus?	Yes	
		Level of Car			,	1. Does the facility maintain a	uany munight census.	103	
	Report Period	Level of Car	e	Report Period	Report Period				
1	150	Chilled (CME)		150	54,750	G. Do pages 3 & 4 include expo			
2	130	Skilled (SNF) Skilled Pediatri	c (SNF/PFD)	130	34,730	investments not directly related YES X N	NO		
3		Intermediate (I				TES A	,0		
4		Intermediate/D				H. Does the BALANCE SHEE	T (naga 17) raflact any r	ion cara assats?	
5		Sheltered Care					NO X	ion-care assets.	
6		ICF/DD 16 or I	` /						
		101/22 10 01 1	1000			I. On what date did you start p	providing long term care	e at this location?	
7	150	TOTALS		150	54,750	Date started	01-Oct-71		
						J. Was the facility purchased o	or leased after January 1	1, 1978?	
	B. Census-For	the entire report period.				YES Date		NO X	
	1	2	3	4	5	1			
	Level of Care	Patient Days by	Level of Care and Pri	imary Source of Paymer	nt	K. Was the facility certified for	r Medicare during the re	eporting year?	
		Public Aid				YES X N	NO If	YES, enter number	
		Recipient	Private Pay	Other	Total	of beds certified	and days	s of care provided	2,577
8	SNF	1,171	628	2,577	4,376				
9	SNF/PED					Medicare Intermediary M	Mutual of Omaha		
	ICF	29,658	14,617		44,275				
	ICF/DD					IV. ACCOUNTING BASIS			
	SC					<u></u>	MODIFIED		
13	DD 16 OR LESS					ACCRUAL	CASH*	X CASH*	
14	TOTALS	30,829	15,245	2,577	48,651	Is your fiscal year identical to	your tax year?	YES X	NO
	C. D	(C-1 5 1' 4	4 3:: 3 - 3 1 4-4 11'			T V	2/21/2001 Final V	12/21/2001	
		cupancy. (Column 5, line 1 1 line 7, column 4.)	4 divided by total lice 88.86%	ensea		Tax Year: 12 * All facilities other than gover	2/31/2001 Fiscal Year:	12/31/2001	<u>—</u>
	bed days on		00.00/0	-		An facilities other than gover	innental must report on	i tiit atti uai vasis.	

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01/01/2001

23,828

146,482

657,726

187

3,521

9,062

1,210,585

4,985,867

(252

(7,118)

214,717

183,337

Ending:

20

21

22

23

24

25

26

27

28

29

Report Period Beginning:

0018150

		Costs Per General Ledger Ses Salary/Wage Supplies Other				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	292,365	18,379	8,549	319,293		319,293		319,293			1
2	Food Purchase		276,079		276,079		276,079	(29,521)	246,558			2
3	Housekeeping	156,278	30,594		186,872		186,872		186,872			3
4	Laundry	107,110	35,256		142,366	(12,502)	129,864	(6,190)	123,674			4
5	Heat and Other Utilities			186,330	186,330		186,330		186,330			5
6	Maintenance	105,175	41,128	17,831	164,134		164,134	4,331	168,465			6
7	Other (specify):*											7
8	TOTAL General Services	660,928	401,436	212,710	1,275,074	(12,502)	1,262,572	(31,380)	1,231,192			8
	B. Health Care and Programs											
9	Medical Director			300	300		300		300			9
10	Nursing and Medical Records	2,061,049	15,200	167,533	2,243,782	12,502	2,256,284		2,256,284			10
10a				130,052	130,052		130,052		130,052			10a
11	Activities	72,838	2,246	1,488	76,572		76,572		76,572			11
12	Social Services	78,259	1,135	1,488	80,882		80,882		80,882			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,212,146	18,581	300,861	2,531,588	12,502	2,544,090		2,544,090			16
	C. General Administration											
17	Administrative	83,746		58,726	142,472		142,472	(5,776)	136,696			17
18	Directors Fees							41,496	41,496			18
19	Professional Services			5,220	5,220		5,220	186,367	191,587			19

23,828

153,852

657,726

3,708

9,062

995,868

4,802,530

252

(252)

187

(187)

24,080

153,600

657,726

187

3,521

9,062

995,868

4,802,530

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

110,670

194,416

3,067,490

McLean County Nursing Home

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

Facility Name & ID Number

20 Dues, Fees, Subscriptions & Promotions

21 Clerical & General Office Expenses

22 Employee Benefits & Payroll Taxes

25 Other Admin. Staff Transportation 26 Insurance-Prop.Liab.Malpractice

28 TOTAL General Administration

TOTAL Operating Expense

29 (sum of lines 8, 16 & 28)

23 Inservice Training & Education

24 Travel and Seminar

27 Other (specify):*

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

15,911

15,911

435,928

23,828

27,271

657,726

3,708

9,062

785,541

1,299,112

V. COST CENTER EXPENSES (continued)

			Cost Per General Ledger ry/Wage Supplies Other Total				Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	T
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			175,917	175,917		175,917	2,708	178,625			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			175,917	175,917		175,917	2,708	178,625			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		124,392		124,392		124,392		124,392			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		124,392	82,125	206,517		206,517		206,517			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,067,490	560,320	1,557,154	5,184,964		5,184,964	186,045	5,371,009			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number

McLean County Nursing Home

0018150

Report Period Beginning:

01/01/2001

Page 5 **Ending:**

12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	In column 2	1 1	2	3	T
		_	Refer-	OHF USE	
	NON-ALLOWABLE EXPENSES	Amount	ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(910)	2.2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,588	30.3		9
10	Interest and Other Investment Income		32.3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
	Income Taxes and Illinois Personal				
	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		20.2		27
	Yellow Page Advertising	(40.051)	20.3		28
29	Other-Attach Schedule	(42,051)		Φ.	29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (40,373)		\$	30

	OHF USE ONLY	,				
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

2

		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	226,418		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 226,418		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 186,045		37

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions.)

Ì	Ź	Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1. Enter below the names of ALE owners and related organizations (parties) as defined in the methodisms. Attach an additional solidation in necessary.										
1		2	3							
OWNERS		RELATED NURSING HOMES	OTHER RELATED BUSINESS ENTITIES							
Name O)wnership %	Name	City	Name	City	Type of Business				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sche	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	V	6	Lawn Service	\$	City of Normal		\$ 4,331	\$ 4,331	1
2	V	18	County Board		McLean County	100.00%	41,496	41,496	2
3	V		Information Services		McLean County	100.00%	9,090	9,090	
4	V		County Administrator	58,726	McLean County	100.00%	52,950	(5,776)) 4
5	V		County Auditor		McLean County	100.00%	57,361	57,361	5
6	V	19	County Treasurer		McLean County	100.00%	119,916	119,916	6
7	V							-	7
8	V							-	8
9	V							-	9
10	V							-	10
11	V							-	11
12	V							-	12
13	V							-	13
14	Total			\$ 58,726			\$ 285,144	\$ * 226,418	14

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

#

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12/31/2001

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VII. RELATED PARTIES (continued)

Facility Name & ID Number

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5		6	7		8	
						Average Ho	ours Per Work				
					Compensation	Week De	voted to this	Compensation	n Included	Schedule V.	
					Received	Facility and % of Total		in Costs for this		Line &	İ
				Ownership	From Other	Wor	k Week	Reporting Period**		Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11					_	_					11
12											12
13								TOTAL	\$		13

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

^{**} This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

STATE OF	ILLINOIS			Page
// 0010170	n (n i in i i	04/04/2004	E 1.	40/04/0004

			J	221.1010			- "5" "
Facility Name & ID Number	McLean County Nursing Home	#	0018150	Report Period Beginning:	01/01/2001	Ending:	12/31/2001
VIII. ALLOCATION OF INDIRE	CT COSTS			Name of Related	Organization	McLean County Gove	rnment
A. Are there any costs included or parent organization costs	in this report which were derived from allocations of ? (See instructions.) YES X	central office NO		Street Address		104 West Front Street	
•		NO		City / State / Zip Phone Number	Code	Bloomington, IL 61 (309) 888-5110	702
B. Show the allocation of costs	below. If necessary, please attach worksheets.			Fax Number		(309) 888-5111	

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	18	County Board	Expenditures	100,000	46 Funds	\$ 327,459	\$ 101,681	12,672		1
2	19	Information Services	% of Effort	100,000	46 Funds	1,950,586	682,869	466	9,090	2
3	17	County Administrator	FTE	100,000	46 Funds	512,285	244,611	10,336	52,950	3
4	19	County Auditor	Transactions	100,000	46 Funds	499,050	208,335	11,494	57,361	4
5	19	County Treasurer	Warrants	100,000	46 Funds	739,718	217,524	16,211	119,916	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,029,098	\$ 1,455,020		\$ 280,813	25

0018150

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10	
	Name of Lender	Related**	Purpose of Loan	Monthly Payment	Date of		ount of Note	Maturity Date	Interest Rate	Reporting Period Interest	
		YES NO		Required	Note	Original	Balance		(4 Digits)	Expense	\perp
	A. Directly Facility Related	_									
	Long-Term			1	1	T _a		1	<u> </u>	•	
1						\$ -	\$ -			\$ -	1
2						-	-			-	2
3						-	-			-	3
4						-				-	4
5						-	-			-	5
	Working Capital										
6						-	-			-	6
7						-	-			-	7
8						-	-			-	8
9	TOTAL Facility Related					\$	\$ -			\$	9
	B. Non-Facility Related*				1	1					1.0
10						-	-			_	10
11						-	-			-	11
12						-	-			-	12
13						-				-	13
14	TOTAL Non-Facility Related					\$ -	\$ -	_	<u>.</u>	\$ -	14
	TOTALS (line 9+line14)		uld be edinated out an mage 5 lin			\$	\$ -			\$ -	15

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Number McLean County Nursing Home # 0018150 **Report Period Beginning:** 01/01/2001 Ending:

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued) **B.** Real Estate Taxes

	Important, please see the next worksheet, "F	RE Tax". The real estate	e tax statement and		
1. Real Estate Tax accrual used on 2000 report.	bill must accompany the cost report.			e	
1. Real Estate Tax accidal used on 2000 report.				Φ	1
2. Real Estate Taxes paid during the year: (Indicate the ta	ax year to which this payment applies. If payment covers mo	ore than one year, detail below	7.)	\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
	and explain your calculation of this accrual on the lines belo	w.)		\$	4
* *	NOT been included in professional fees or other general op s of invoices to support the cost and a copy of			\$	5
6. Subtract a refund of real estate taxes. You must offset classified as a real estate tax cost plus one-half of any TOTAL REFUND \$ For	• • • • • • • • • • • • • • • • • • • •	al estate tax appeal boa	ard's decision.)	\$	6
7. Real Estate Tax expense reported on Schedule V, line	33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:					
	996 8		FOR OHF USE ONLY		
1	997 9 998 10	13	FROM R. E. TAX STATEMENT FO	R 2000 \$	13
_	999 11 000 12	14	PLUS APPEAL COST FROM LINE	5 \$	14
	15 LESS REFUND FROM LINE		LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CAL	_CULATION \$	16

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.

 This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE
TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION
In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs. as well as copies of your real estate tax bills for calendar 2000.
Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.
Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

CILITY NAME	McLean County Nursing I	Home		COUNTY	McLean
CILITY IDPH LICEN	SE NUMBER 0	018150			
NTACT PERSON RE	GARDING THIS REPO	ORT Donald Lee			
EPHONE (309)	888-5380	F.	AX #: (309)	454-4594	
Summary of Real	Estate Tax Cost	_			
cost that applies to home property which	number and real estate the operation of the nur ch is vacant, rented to o D. Do not include cost	sing home in Column ther organizations, or	D. Real estate t used for purpose	ax applicable to an es other than long t	y portion of the nursing
(A)		(B)		(C)	(D) <u>Tax</u>
Tax Index I	Number	Property Descript	ion	Total Tax	Applicable to Nursing Home
			_	\$ -	\$
				\$	
				\$	
				\$	
				\$	
				\$	<u> </u>
				\$	
				\$	
				\$	_ \$
·				\$	<u> </u>
		то	TALS	\$	\$
Real Estate Tax C	ost Allocations				
Does any portion or used for nursing ho	f the tax bill apply to mome services?	ore than one nursing h		perty, or property	which is not directly
	xplanation & a schedule estate tax cost must be a				
Tax Bills					
Attach a copy of the	e 2000 tax bills which v	vere listed in Section	A to this stateme	nt. Be sure to use	the 2000 tax bill which

					STATE OF	FILLINOIS						Page 11
	ity Name & ID Number		ean County Nursing Home		#	0018150	Report Pe	eriod Beginning:		01/01/2001 Endin	ıg:	12/31/2001
X. BU	JILDING AND GENERAL INF	ORMATION:										
A.	Square Feet:	58,065	B. General Construction Type:	Exterior	Brick		Frame	Steel		Number of Stories	One	
C.	Does the Operating Entity?	X	(a) Own the Facility	(b) Rent from a	a Related Or	ganization.				(c) Rent from Completely Organization.	Unrelate	ed
	(Facilities checking (a) or (b)	must complete S	Schedule XI. Those checking (c) m	ay complete Schedule XI o	r Schedule Y	III-A. See in	structions.)					
D.	Does the Operating Entity?	X	(a) Own the Equipment	(b) Rent equip	ment from a	Related Org	ganization.			(c) Rent equipment from (Unrelated Organization		ely
	(Facilities checking (a) or (b)	must complete S	Schedule XI-C. Those checking (c)	may complete Schedule X	I-C or Sched	lule XII-B. S	ee instructio	ons.)				
E.	(such as, but not limited to, a)	artments, assis	operating entity or related to the operating facilities, day training fa tage, and number of beds/units ava	cilities, day care, independ	dent living fa							
	-											
F.	Does this cost report reflect a If so, please complete the follo		or pre-operating costs which are b	peing amortized?				YES	X	NO		
1.	Total Amount Incurred:				2. Number	of Years Ov	er Which it	is Being Amortize	ed:			
3.	Current Period Amortization:	'			4. Dates In	curred:						
		N - 4-	are of Costs:		_							
		Nati	ire of Costs: (Attach a complete schedule deta	iling the total amount of o	rganization	and nre-one	rating costs.)				
			(French a complete schedule deta	aning the total amount of o	- Sumzution	and pre ope	uting costs.	,				
XI. O	WNERSHIP COSTS:			_		_						
	A. Land.	-	Use I	Square Feet	Voor	Agguired	1	Cost	1			
	A. Lailu.	1	Use	Square reet	1 ear	Acquired	\$	15,000	1			
		2					<u> </u>	12,000	2			
		3	TOTALS				\$	15,000	3			

01/01/2001 Ending: Page 12 12/31/2001 Facility Name & ID Number McLean County Nursing Home **Report Period Beginning:** 0018150

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	Depreciation-including Fixed Equip	2	3	4	5	6	7	8	9	Т
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	150		1974	01/01/74	\$ 2,907,918	\$ 72,695	40	\$ 72,698	\$ 3	\$ 1,981,297	4
5			1975	01/01/75	66,046	1,652	40	1,651	(1)	43,890	5
6			1976	01/01/76	32,940	825	40	824	(1)	21,081	6
7											7
8											8
	Improver	ment Type**									
9	Paging System			12/07/89	2,588	129	20	129		1,549	9
10	Smoke Detectors			12/01/89	2,418		5			2,418	10
	Air Cond & Boiler	r		11/30/79	40,718		40	1,018	1,018	26,141	11
12	Roof Repairs			06/29/82	3,374	169	40	84	(85)	1,596	12
13	Smoke Damper			07/01/83	3,600	180	40	90	(90)	1,710	13
14	Various - 1984			05/09/84	58,471	2,924	20	2,924		52,088	14
	Fan Coil Units			04/13/84	1,158		15			1,158	15
16	Temp Sensors			02/13/85	499		10			499	16
	Wood shed	100 0 1 7 1		07/01/85	749		15	0.0	20	749	17
18	Sewer Machine &			04/30/86	1,592	60	20	80	20	1,217	18
19	Rear Door - Vestil	bule		01/26/84	1,962	49	40	49	246	882	19
	Various - 1987	alt		05/06/87	19,471 19,249	728	20	974	246	14,079	20
	Concrete & Aspha Fire Doors	ait		06/16/87 06/04/88	1,070	54	20	54		19,249 755	22
	Replace Roof			08/16/88	481,262	26,515	18	26,737	222	347,581	23
	Boiler Repairs			12/19/89	917	20,313	10	20,737	LLL	917	24
25		Rldg		10/05/89	5,521	221	25	221		2,651	25
26	Telephone System			01/01/88	4,250	170	25	170		2,380	26
	Courtyard Repairs			05/23/89	2,191	83	20	110	27	1,320	27
	Fire Alarm Contro			11/21/89	5,072		10			5,072	28
29	Capital Improvem			07/13/90	21,349	644	15	1,423	779	17,076	29
	Capital Improvem			03/27/91	2,390	120	20	120	-	1,320	30
	Heat Exchanger			03/21/91	2,236		10			2,236	31
		ning Room Remodel		05/29/92	6,350	173	40	159	(14)	1,475	32
33	Direct Cable - 500	Ft.		02/27/92	168	7	23	7	• /	70	33
	Closure & Power I			05/19/92	2,545	255	10	255		2,306	34
35	Boilers (2) & Stack	ks		10/07/92	63,200	3,160	20	3,160		28,440	35
36	Toilet Rails & Wa	ter Booster		06/29/93	2,585	172	15	172		1,463	36

^{*}Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12A 12/31/2001 Facility Name & ID Number McLean County Nursing Home 0018150 Report Period Beginning: 01/01/2001 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

B. Building Depreciation-Including Fixed Equipment. (See instruction	3	4	5	6	7	8	9	$\overline{}$
	Year	•	Current Book	Life	Straight Line	Ü	Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
37 Storage Tank	11/08/93	\$ 10,558	\$ 211	50	\$ 211	\$	\$ 1,719	37
38 Stairsteps	11/08/93	289	10	30	10		81	38
39 Air Cond & Boiler	11/30/80	9,889		20	494	494	4,446	39
40 Remodel Nurses Station	04/13/94	2,283	152	15	152		1,173	40
41 Air Cond Units (2)	07/19/94	79,305	5,287	15	5,287		39,399	41
42 IDPA Audit	01/01/92	4,243		10	424	424	3,816	42
43 Kitchen Walk-in Freezer/Cooler	10/30/96	11,038	552	20	552		2,854	43
44 Closed Circuit TV System-Recorder	02/27/98	3,208	642	5	642		2,466	44
45 NT System Wiring & Switches	12/22/98	4,222	844	5	844		2,553	45
46 Bathroom Improvements	08/19/99	9,505	951	10	951		2,288	46
47 Four Water Coolers	07/20/99	2,089	209	10	209		512	47
48 Aluminum Cubicle Track	09/10/99	7,578	379	20	379		874	48
49 Roofing Repairs	05/20/99	29,217	1,461	20	1,461	0	3,823	49
50 Cooridor Fire Doors	12/12/99	4,495	225	20	225		462	50
51 Time Clock System	07/13/99	7,144	476	15	476		1,175	51
52 Lamp Fixture Improvement	08/01/00	1,218	122	10	122		173	52
53 Room Remodeling Project 2000	12/31/00	39,599		15	2,640	2,640	2,640	53
54 Kitchen Disposal Unit	06/15/00	1,789	224	8	224		346	54
55 Room Remodeling Project 2000	01/01/01	40,993	5,373	15	2,725	(2,648)	2,725	55
56 Life Safety Project	10/22/01	8,137	90	15	104	14	104	56
57 Door Lock Project	03/28/01	31,078	1,554	15	1,578	24	1,578	57
58				-				58
59				-				59
60				-				60
61				-				61
62				-				62
63				-				63
64				-				64
65				-				65
66				-				66
67				-				67
68				_				68
69				-				69
70 TOTAL (lines 4 thru 69)		\$ 4,071,737	\$ 129,747		\$ 132,819	\$ 3,072	\$ 2,659,872	70

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12B Facility Name & ID Number McLean County Nursing Home 0018150 **Report Period Beginning:** 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

32

34 TOTAL (lines 1 thru 33)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. 6 Life Year Straight Line Accumulated **Current Book** Cost Depreciation Depreciation Adjustments Depreciation Improvement Type** Constructed in Years 4,071,737 129,747 132,819 3,072 2,659,872 Totals from Page 12A, Carried Forward 5 6 11 11 12 12 13 13 14 14 15 15 16 16 17 17 19 20 20 22 22 23 23 24 24 25 26 26 27 27 28 28 29 29 30 30 31 31

4,071,737

129,747

132,819

3,072

32 33

2,659,872

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12C Facility Name & ID Number McLean County Nursing Home 0018150 **Report Period Beginning:** 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

31

32

34 TOTAL (lines 1 thru 33)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. 6 Life Year Straight Line Accumulated **Current Book** Cost Depreciation Depreciation Adjustments Depreciation Improvement Type** Constructed in Years 4,071,737 129,747 132,819 3,072 2,659,872 Totals from Page 12B, Carried Forward 5 6 11 11 12 12 13 13 14 14 15 15 16 16 17 17 19 20 20 22 22 23 23 24 24 25 26 26 27 27 28 28 29 29 30 30

4,071,737

129,747

132,819

3,072

31

32 33

2,659,872

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12D Facility Name & ID Number McLean County Nursing Home 0018150 **Report Period Beginning:** 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. 6 Life Year Straight Line Accumulated **Current Book** Cost Depreciation Depreciation Adjustments Depreciation Improvement Type** Constructed in Years 4,071,737 129,747 132,819 3,072 2,659,872 Totals from Page 12C, Carried Forward 5 6 11 11 12 12 13 13 14 14 15 15 16 16 17 17 19 20 20 22 22 23 23 24 24 25 26 26 27 27 28 28 29 29 30 30 31 31 32 32 33 34 TOTAL (lines 1 thru 33) 4,071,737 129,747 132,819 3,072 2,659,872

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12E Facility Name & ID Number McLean County Nursing Home 0018150 **Report Period Beginning:** 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. 6 Life Year Straight Line Accumulated **Current Book** Cost Depreciation Depreciation Adjustments Depreciation Improvement Type** Constructed in Years 4,071,737 129,747 132,819 3,072 2,659,872 Totals from Page 12D, Carried Forward 5 6 11 11 12 12 13 13 14 14 15 15 16 16 17 17 19 20 20 22 22 23 23 24 24 25 26 26 27 27 28 28 29 29 30 30 31 31 32 32 33 34 TOTAL (lines 1 thru 33) 4,071,737 129,747 132,819 3,072 2,659,872

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12F Facility Name & ID Number McLean County Nursing Home 0018150 **Report Period Beginning:** 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. 6 Life Year Straight Line Accumulated **Current Book** Cost Depreciation Depreciation Adjustments Depreciation Improvement Type** Constructed in Years 4,071,737 129,747 132,819 3,072 2,659,872 Totals from Page 12E, Carried Forward 5 6 11 11 12 12 13 13 14 14 15 15 16 16 17 17 19 20 20 22 22 23 23 24 24 25 26 26 27 27 28 28 29 29 30 30 31 31 32 32 33 34 TOTAL (lines 1 thru 33) 4,071,737 129,747 132,819 3,072 2,659,872

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12G Facility Name & ID Number McLean County Nursing Home 0018150 **Report Period Beginning:** 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. 6 Life Year Straight Line Accumulated **Current Book** Cost Depreciation Depreciation Adjustments Depreciation Improvement Type** Constructed in Years 4,071,737 129,747 132,819 3,072 2,659,872 Totals from Page 12F, Carried Forward 5 6 11 11 12 12 13 13 14 14 15 15 16 16 17 17 19 20 20 22 22 23 23 24 24 25 26 26 27 27 28 28 29 29 30 30 31 31 32 32 33 34 TOTAL (lines 1 thru 33) 4,071,737 129,747 132,819 3,072 2,659,872

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12H Facility Name & ID Number McLean County Nursing Home 0018150 **Report Period Beginning:** 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued) B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

24

26

27

28

29 30

31

32

34 TOTAL (lines 1 thru 33)

6 Life Year Straight Line Accumulated **Current Book** Cost Depreciation Depreciation Adjustments Depreciation Improvement Type** Constructed in Years 4,071,737 129,747 132,819 3,072 2,659,872 Totals from Page 12G, Carried Forward 5 6 11 11 12 12 13 13 14 14 15 15 16 16 17 17 19 20 20 22 22 23 23

4,071,737

129,747

132,819

3,072

24 25

26

27 28

29

30

31

32 33

2,659,872

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12I Facility Name & ID Number McLean County Nursing Home 0018150 **Report Period Beginning:** 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

31

32

34 TOTAL (lines 1 thru 33)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. 6 Life Year Straight Line Accumulated **Current Book** Cost Depreciation Depreciation Adjustments Depreciation Improvement Type** Constructed in Years 4,071,737 129,747 132,819 3,072 2,659,872 Totals from Page 12H, Carried Forward 5 6 11 11 12 12 13 13 14 14 15 15 16 16 17 17 19 20 20 22 22 23 23 24 24 25 26 26 27 27 28 28 29 29 30 30

4,071,737

129,747

132,819

3,072

31

32 33

2,659,872

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 13 12/31/2001 Facility Name & ID Number McLean County Nursing Home **Report Period Beginning:** 01/01/2001 **Ending:** 0018150

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of	1	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 621,308	\$ 45,276	\$ 45,276	\$	various	\$ 431,436	71
72	Current Year Purchases	8,419	229	229		various	229	72
73	Fully Depreciated Assets	154,774				various	154,774	73
74								74
75	TOTALS	\$ 784,501	\$ 45,505	\$ 45,505	\$		\$ 586,439	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance	Pick-up, '96 Dodge 4 x 4	01/18/96	\$ 19,549	\$ 226	\$ 181	\$ (45)	5	\$ 19,549	76
77	Patient Transport	Bus, '81 Ford	10/05/82	26,620				15	26,620	77
78	Maintenance	Tractor, Sears	09/30/96	3,509	439		(439)	5	3,509	78
79										79
80	TOTALS			\$ 49,678	\$ 665	\$ 181	\$ (484)		\$ 49,678	80

E. Summary of Care-Related Assets

	E. Summary of Care-Related Assets	1	2		
		Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,920,916	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 175,917	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 178,505	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,588	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,295,989	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

Facil	ity Name & ID	Number	McLean County Nursir	ng Home	#	# 0018150		Report Po	eriod Begir	nning:	01/01/2001	Ending:	12/31/2001
XII.	 Name of Pa Does the fa 	nd Fixed Equipn arty Holding Le	nent (See instructions.) ase: eal estate taxes in addition	n to rental amount sh	own below on line 7,	column 4?YES	NO						
		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Yea of Lease		6 Cotal Years ewal Option*					
3	Original Building:			S					3		lates of current r	_	nt:
4	Additions								4	Ending			
5									5	G			
6	mom . r								6		paid in future ye	ears under the	current
	TOTAL			3	**				/	rental agre	eement:		
	This amou by the length 9. Option to 18. Equipment	nt was calculate gth of the lease Buy: -Excluding Trar	zation of lease expense ind by dividing the total am YES Tapportation and Fixed Equation in the specific property is portaged.	ount to be amortized NO Terms:			*			Fiscal Year 12. 13. 14.	/2002 /2003 /2004	Annual Re \$ \$ \$ \$	nt
			ntal included in building in building in the second of the	rental?	Description:	YES	NO						
		ntal (See instruc				(Attach a sch	edule detaili	ng the breakdov	vn of mova	ble equipment)			
	1		2	3	·	4							
	Use		Model Year and Make	Monthly Payr		Rental Exp for this Pe				* If there	is an option to bu	ıv the building	
17			anu make	\$	ilent (\$	ilou	17			rovide complete		
18								18		schedule			
19 20								19 20		** This am	ount plus any am	nortization of l	0050
	TOTAL			\$		<u> </u>		21			must agree with		
41	IUIAL			Ψ		Ψ		∠ 1		CAPCHSE	must agree with	page 7, mit 34	<u>.</u>

Page 14

STATE	OF	ш	JIN	OIS

Facility Name & ID Number McLean County Nursing Home 0018150 **Report Period Beginning:** 01/01/2001 Ending: 12/31/2001 XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.) A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.) 1. HAVE YOU TRAINED AIDES YES **CLASSROOM PORTION:** 3. **CLINICAL PORTION: DURING THIS REPORT** PERIOD? X NO **IN-HOUSE PROGRAM IN-HOUSE PROGRAM** IN OTHER FACILITY IN OTHER FACILITY If "yes", please complete the remainder of this schedule. If "no", provide an **COMMUNITY COLLEGE HOURS PER AIDE** explanation as to why this training was not necessary. **HOURS PER AIDE B. EXPENSES** C. CONTRACTUAL INCOME ALLOCATION OF COSTS (d) In the box below record the amount of income your facility received training aides from other facilities. Facility Drop-outs Completed Contract Total **Community College Tuition** D. NUMBER OF AIDES TRAINED **Books and Supplies** Classroom Wages (a) 4 Clinical Wages (b) In-House Trainer Wages (c)

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(e)

(c) For in-house training programs only. Do not include fringe benefits.

6 Transportation

TOTALS

Contractual Payments
Nurse Aide Competency Tests

SUM OF line 9, col. 1 and 2

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

IDEN OF THE ESTIMATED	
COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

Page 15

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number McLean County Nursing Home STATE OF ILLINOIS Page 16

0018150 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
		Schedule V	Staf	f	Outside	Outside Practitioner				
	Service	Line & Column	Units of	Cost	(other th	(other than consultant)		Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. $3 + 5 + 6$)	
1	Licensed Occupational Therapist	10a.3	hrs	\$	315	\$ 18,060	\$	315 \$	18,060	1
	Licensed Speech and Language									
2	Development Therapist	10a.3	hrs		117	2,719		117	2,719	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		234	15,037		234	15,037	4
5	Physician Care	39.3	visits							5
6	Dental Care	39.3	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy	39.2	prescrpts				57,459		57,459	9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Medical Supplies	39.2					66,933		66,933	13
14	TOTAL			\$	666	\$ 35,815	\$ 124,392	666 \$	160,206	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number McLean County Nursing Home # 0018150 Report Period Beginning: 01/01/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

	This report must be completed even if it	1		2 After	
		0	perating	Consolidation*	
	A. Current Assets	Φ.	2 100 551	T _Φ	
1	Cash on Hand and in Banks	\$	3,189,551	\$	1
2	Cash-Patient Deposits		31,854		2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance		570,056		3
4	Supply Inventory (priced at FIFO)		30,326		4
5	Short-Term Investments		109,952		5
6	Prepaid Insurance				6
7	Other Prepaid Expenses				7
8	Accounts Receivable (owners or related parties)				8
9	Other(specify):				9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	3,931,739	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land				13
14	Buildings, at Historical Cost		4,041,840		14
15	Leasehold Improvements, at Historical Cost				15
16	Equipment, at Historical Cost		711,865		16
17	Accumulated Depreciation (book methods)		(3,114,709)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify):				23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	1,638,996	\$	24
	TOTAL ASSETS				
25	(sum of lines 10 and 24)	\$	5,570,735	\$	25

	1 0	perating	2 After Consolidation*	
C. Current Liabilities				
Accounts Payable	\$	(313,690)	\$	26
Officer's Accounts Payable				27
Accounts Payable-Patient Deposits		(31,854)		28
Short-Term Notes Payable				29
Accrued Salaries Payable				30
Accrued Taxes Payable				
(excluding real estate taxes)				31
Accrued Real Estate Taxes(Sch.IX-B)				32
Accrued Interest Payable				33
Deferred Compensation				34
Federal and State Income Taxes				35
Other Current Liabilities(specify):				
Accrued Expenses		(174,411)		36
				37
TOTAL Current Liabilities				
(sum of lines 26 thru 37)	\$	(519,955)	\$	38
D. Long-Term Liabilities				
Long-Term Notes Payable				39
				4(
				41
				42
, (1 V)				43
				44
TOTAL Long-Term Liabilities				
<u> </u>	\$		\$	45
TOTAL LIABILITIES				
	s	(519 955)	S	46
(5 5 5. 6 1)	Ψ	(517,755)	-	+ ``
TOTAL EQUITY(page 18, line 24)	\$	(5.050.780)	s	47
	Ψ	(0,000,100)	1	+ -
(sum of lines 46 and 47)	\$	(5,570,735)	\$	48
	Accounts Payable Officer's Accounts Payable Accounts Payable-Patient Deposits Short-Term Notes Payable Accrued Salaries Payable Accrued Taxes Payable (excluding real estate taxes) Accrued Real Estate Taxes(Sch.IX-B) Accrued Interest Payable Deferred Compensation Federal and State Income Taxes Other Current Liabilities(specify): Accrued Expenses TOTAL Current Liabilities (sum of lines 26 thru 37) D. Long-Term Liabilities Long-Term Notes Payable Mortgage Payable Bonds Payable Deferred Compensation Other Long-Term Liabilities(specify): TOTAL Long-Term Liabilities(specify): TOTAL Long-Term Liabilities(specify): TOTAL Long-Term Liabilities(specify): TOTAL LOng-Term Liabilities (sum of lines 39 thru 44) TOTAL LIABILITIES (sum of lines 38 and 45) TOTAL EQUITY(page 18, line 24) TOTAL LIABILITIES AND EQUITY	C. Current Liabilities Accounts Payable Officer's Accounts Payable Accounts Payable-Patient Deposits Short-Term Notes Payable Accrued Salaries Payable Accrued Taxes Payable (excluding real estate taxes) Accrued Real Estate Taxes(Sch.IX-B) Accrued Interest Payable Deferred Compensation Federal and State Income Taxes Other Current Liabilities(specify): Accrued Expenses TOTAL Current Liabilities (sum of lines 26 thru 37) D. Long-Term Liabilities Long-Term Notes Payable Mortgage Payable Bonds Payable Deferred Compensation Other Long-Term Liabilities(specify): TOTAL Long-Term Liabilities(specify): TOTAL Long-Term Liabilities (sum of lines 39 thru 44) TOTAL LIABILITIES (sum of lines 38 and 45) \$ TOTAL EQUITY(page 18, line 24) TOTAL LIABILITIES AND EQUITY	C. Current Liabilities Accounts Payable Officer's Accounts Payable Accounts Payable-Patient Deposits Short-Term Notes Payable Accrued Salaries Payable Accrued Taxes Payable Accrued Taxes Payable (excluding real estate taxes) Accrued Interest Payable Deferred Compensation Federal and State Income Taxes Other Current Liabilities (sum of lines 26 thru 37) D. Long-Term Liabilities Long-Term Notes Payable Bonds Payable Deferred Compensation Other Long-Term Liabilities(specify): TOTAL Current Liabilities (sum of lines 39 thru 44) TOTAL LIABILITIES (sum of lines 38 and 45) (5,050,780) TOTAL LIABILITIES AND EQUITY	C. Current Liabilities Accounts Payable Officer's Accounts Payable Accounts Payable-Patient Deposits Short-Term Notes Payable Accrued Salaries Payable Accrued Taxes Payable (excluding real estate taxes) Accrued Interest Payable Deferred Compensation Federal and State Income Taxes Other Current Liabilities(specify): Accrued Expenses (174,411) TOTAL Current Liabilities (sum of lines 26 thru 37) D. Long-Term Liabilities Hontzage Payable Bonds Payable Bonds Payable Deferred Compensation TOTAL Long-Term Liabilities(specify): TOTAL Long-Term Liabilities(specify): TOTAL Long-Term Liabilities Sound of lines 39 thru 44) TOTAL Long-Term Liabilities (sum of lines 39 thru 44) TOTAL LIABILITIES (sum of lines 38 and 45) S (519,955) S (519,955) S (519,955)

*(See instructions.)

			STA	ATE OF ILLI	NOIS			Page 18
Facility Name & ID Number	McLean County Nursing Home	#		0018150	Report Period Beginning:	01/01/2001	Ending:	12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

CHA	INGES IN EQUIL I			
			1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	5,047,994	1
2	Restatements (describe):			2
3	Prior Period Adjustment		(17,273)	3
4				4
5				5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	5,030,721	6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		20,059	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe)			15
16	Other (describe)			16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	20,059	17
	B. Transfers (Itemize):			
18				18
19				19
20				20
21				21
22				22
23	TOTAL Transfers (sum of lines 18-22)	\$		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	5,050,780	24

^{*} This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue All Levels of Care	\$ (4,710,481)	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ (4,710,481)	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	(28,611)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	(6,190)	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ (34,801)	23
	D. Non-Operating Revenue		
24	Contributions	(329,841)	24
25	Interest and Other Investment Income***	(121,653)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (451,494)	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous Income	(8,247)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (8,247)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ (5,205,023)	30

		2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,275,074	31
32	Health Care	2,531,588	32
33	General Administration	995,868	33
	B. Capital Expense		
34	Ownership	175,917	34
	C. Ancillary Expense		
35	Special Cost Centers	124,392	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,184,964	40
41	Income before Income Taxes (line 30 minus line 40)**	(20,059)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (20,059)	43

*	This r	nust agree	with 1	page 4.	line 4	15. co	lumn	4.
	I nis i	nust agree	with	oage 4,	line 4	rə, co	iumn	۱ 4

Report Period Beginning:

^{**} Does this agree with taxable income (loss) per Federal Income
Tax Return? Yes If not, please attach a reconciliation.

^{***} See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number McLean County Nursing Home Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	•	1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,927	2,273	\$ 66,354	\$ 29.19	1
2	Assistant Director of Nursing	3,923	4,182	85,769	20.51	2
3	Registered Nurses	16,392	17,885	375,982	21.02	3
4	Licensed Practical Nurses	15,511	17,357	280,634	16.17	4
5	Nurse Aides & Orderlies	114,085	122,821	1,228,000	10.00	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,788	2,100	25,448	12.12	9
10	Activity Assistants	5,268	5,755	47,390	8.23	10
11	Social Service Workers	6,839	7,591	78,259	10.31	11
	Dietician					12
	Food Service Supervisor	1,906	2,082	32,396	15.56	13
	Head Cook	1,962	2,082	23,641	11.35	14
	Cook Helpers/Assistants	29,427	31,526	236,328	7.50	15
	Dishwashers					16
	Maintenance Workers	6,622	7,225	105,175	14.56	17
	Housekeepers	16,952	18,310	156,278	8.54	18
	Laundry	11,473	12,548	107,110	8.54	19
	Administrator	1,967	2,257	83,746	37.11	20
21	Assistant Administrator	1,840	2,079	24,487	11.78	21
22	Other Administrative					22
	Office Manager					23
	Clerical	5,544	6,246	86,183	13.80	24
	Vocational Instruction					25
	Academic Instruction					26
	Medical Director					27
	Qualified MR Prof. (QMRP)					28
	Resident Services Coordinator					29
	Habilitation Aides (DD Homes)					30
31	Medical Records					31
	Other Health Care(specify)					32
33	Other(specify) Ward Clerk	1,916	2,390	24,310	10.17	33
34	TOTAL (lines 1 - 33)	245,342	266,709	\$ 3,067,490 *	\$ 11.50	34

^{*} This total must agree with page 4, column 1, line 45.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid &	Total Consultant Cost for Reporting	Schedule V Line & Column	
		Accrued	Period	Reference	
35	Dietary Consultant	244	\$ 8,549	1.3	35
36	Medical Director		300	9.3	36
37	Medical Records Consultant	20	1,100	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	30	1,488	11.3	44
45	Social Service Consultant	30	1,488	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	324	\$ 12,924		49

C. CONTRACT NURSES

		1	2		3	
		Number			Schedule V	
		of Hrs.	Tota	al	Line &	
		Paid &	Contr	act	Column	
		Accrued	Wag	es	Reference	
50	Registered Nurses		\$			50
51	Licensed Practical Nurses	281		8,834	10.3	51
52	Nurse Aides	8,673	15	7,100	10.3	52
53	TOTAL (lines 50 - 52)	8,954	\$ 16	5,933		53

^{**} See instructions.

STATE OF ILLINOIS		Pag	ge 21	
# 0018150	Report Period Beginning:	01/01/2001	Ending:	12/31/2001

)F ILLINOIS				Pa	ge 21
Facility Name & ID Number	McLean County Nurs	ing Home		# 0018150		Report Per	iod Beginn	ning: 01/01/2001	Ending:	12/31/200
XIX. SUPPORT SCHEDULES										
A. Administrative Salaries		Ownership		D. Employee Benefits and Payrol				F. Dues, Fees, Subscriptions and	Promotions	
Name	Function	%	Amount	Description			ount	Description		Amount
		\$	5	Workers' Compensation Insuran		\$	17,701	IDPH License Fee	:	\$
Oonald Lee	Administrator	-0-	83,746	Unemployment Compensation In	surance			Advertising: Employee Recruitr	nent	15,74
				FICA Taxes			32,738	Health Care Worker Backgroun	d Check	
				Employee Health Insurance			67,015	(Indicate # of checks performed		
				Employee Meals		_		Life Services Network of Illinois		7,6
				Illinois Municipal Retirement Fu	nd (IMRF)*		36,601	Nursing Books & Subscriptions		2
				minois wunterpar Retirement Fu	na (marki)		30,001	Other Dues		20
COTAL (4- C-b-d-l- V I	C 17 - 1 1)			F1 H:6				Other Dues		
TOTAL (agree to Schedule V, l		đ	02.746	Employee Uniforms			2.671			
List each licensed administrate	or separately.)	<u> </u>	83,746	Employee Physicals			3,671			
3. Administrative - Other						_				
								Less: Public Relations Expense		
Description			Amount			<u></u>		Non-allowable advertising	g (
		9	3			_		Yellow page advertising	(
County Administration Fee			58,726							
			TOTAL (agree to Schedule V,		\$ 6	57,726	TOTAL (agree to S	ch. V,	\$ 23,8	
				line 22, col.8)				line 20, col		
TOTAL (agree to Schedule V, l	line 17, col. 3)	<u> </u>	58,726	E. Schedule of Non-Cash Compe	nsation Paid			G. Schedule of Travel and Semi		
(Attach a copy of any managem		·		to Owners or Employees						
C. Professional Services	ient sei vice agreement)			to Owners of Employees				Description		Amount
Vendor/Payee	True		A 4	Description	I : #	A	4	Description		Amount
v endor/Payee	Type	ď	Amount	Description	Line#		ount	O 4 654 4 TF 1	i	rh.
DOD G. III	0 1:	<u> </u>				\$		Out-of-State Travel		
R&R Consulting	Consulting		40							
Robert Rein, CPA	Consulting		4,430							
Charles Butzow	Consulting		750		<u> </u>	<u></u>		In-State Travel		79
					_	_				
								Seminar Expense		2,7
		_			_	_				
										-
								Endands and Employee		
FOTAL (4- C-L-3-1-X)	L. 10 - L. 2)			TOTAL		C	ļ	Entertainment Expense	<u> </u>	
ΓΟΤΑL (agree to Schedule V, I				TOTAL		\$		(agree to Sch.	· ·	-
(If total legal fees exceed \$2500	attach copy of invoices.)	\$	5,220					TOTAL line 24, col. 8	5)	\$ 3,52

^{*} Attach copy of IMRF notifications

^{**}See instructions.

Ending:

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

McLean County Nursing Home

Facility Name & ID Number

(See instructions.) 10 12 1 2 11 13 Month & Year **Amount of Expense Amortized Per Year** Improvement **Improvement Total Cost** Useful **Was Made** FY1998 FY2006 Type FY1999 FY2000 FY2001 FY2002 FY2003 FY2004 FY2005 Life 2 3 5 6 8 9 10 12 13 14 15 16 17 18 19 20 TOTALS

0018150

X. GENERAL INFORMATION: (1) Are nursing employees (RN,LPN,NA) represented by a union? (2) Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount. Life Services Network of Illinois (3) Did the nursing home make political contributions or payments to a political (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For exception of the building used for any function other than long term care services for the patient census listed on page 2, Section B?	ding: 12/31/200 ⁻
(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? (2) Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount. Life Services Network of Illinois 7,655 (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For exception of the patient census listed on page 2, Section B?	
the Department of Public Aid, in addition to the daily rate, been properly classified (2) Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount. Life Services Network of Illinois 7,655 (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example 1.	
(2) Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount. Life Services Network of Illinois 7,655 (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For exception of Schedule V? Yes In the Ancillary Section of Schedule V?	
If YES, give association name and amount. Life Services Network of Illinois 7,655 (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example 1. No For example 2. Section B?	
(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example 1. No For example 2.	
(3) Did the nursing home make political contributions or payments to a political the patient census listed on page 2, Section B? No For example, and the patient census listed on page 2, Section B?	
action organization? No If YES, have these costs is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach	
been properly adjusted out of the cost report? a schedule which explains how all related costs were allocated to these functions.	
(4) Does the bed capacity of the building differ from the number of beds licensed at the (15) Indicate the cost of employee meals that has been reclassified to employee benefits	
end of the fiscal year? No If YES, what is the capacity? If YES, what is the capacity? If YES, what is the capacity? On Schedule V. \$ Has any meal income been offset	t against
related costs? Yes Indicate the amount. \$	910
(5) Have you properly capitalized all major repairs and equipment purchases? Yes	710
What was the average life used for new equipment added during this period? (16) Travel and Transportation	
a. Are there costs included for out-of-state travel?	
(6) Indicate the total amount of both disposable and non-disposable diaper expense If YES, attach a complete explanation.	
and the location of this expense on Sch. V. \$ 12,502 Line 10.2 b. Do you have a separate contract with the Department to provide medical transporta	ition for
residents? No If YES, please indicate the amount of income earned fro	
(7) Have all costs reported on this form been determined using accounting procedures program during this reporting period. \$	
consistent with prior reports? Yes If NO, attach a complete explanation. c. What percent of all travel expense relates to transportation of nurses and patients?	N/A
d. Have vehicle usage logs been maintained? N/A	
(8) Are you presently operating under a sale and leaseback arrangement? e. Are all vehicles stored at the nursing home during the night and all other	
If YES, give effective date of lease. No times when not in use? Yes	
f. Has the cost for commuting or other personal use of autos been adjusted	
(9) Are you presently operating under a sublease agreement? YES X NO out of the cost report? N/A	
g. Does the facility transport residents to and from day training?	No
(10) Was this home previously operated by a related party (as is defined in the instructions for Indicate the amount of income earned from providing such	
Schedule VII)? YES NO X If YES, please indicate name of the facility, transportation during this reporting period.	
IDPH license number of this related party and the date the present owners took over.	**
(17) Has an audit been performed by an independent certified public accounting firm?	Yes
	structions for the
of Public Aid during this cost report period. \$ 82,125 been attached? No If no, please explain. Audit report not issued this amount is to be recorded on line 42 of Schedule V.	d.
(18) Have all costs which do not relate to the provision of long term care been adjusted out	+
(12) Are there any salary costs which have been allocated to more than one line on Schedule V out of Schedule V? Yes	ι
for an individual employee? Yes If YES, attach an explanation of the allocation.	
Laundry & Hskpg. Split on time spent. (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of service	es
performed been attached to this cost report? Yes	
Attach invoices and a summary of services for all architect and appraisal fees.	